Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 07/03/01.
   b. The request was received on 06/27/02.

II. EXHIBITS

1. Requestor:
   a. Initial Submission of TWCC-60
      1. UB-92s
      2. EOB(s)
   b. Additional documentation received on 07/29/02
      1. Position Statement
      2. Example EOB(s) from other carriers
      3. Medical Records
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit 2:
   a. Response to a Request for Dispute Resolution received on 08/19/02
   b. SOAH decisions
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 07/31/02. Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on 08/01/02. The response from the insurance carrier was received in the Division on 08/08/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 08/08/02
   "(Carrier) has unfairly reduced our bill when other workers' compensation carriers have established that our charges are fair and reasonable because they are paying 85%-100% of our billed charges. Also group insurance companies are allowing 100% of our billed charges. Enclosed are examples of bills for the same type of treatment of other patients

and their insurance companies [sic] interpretation of fair and reasonable as shown by the amounts paid."

2. Respondent: Letter dated 08/08/02
"The Carrier, in determining what constitutes a 'fair and reasonable rate' did consider the Medicare, PPO and HMO payments, and reviewed the Commission's own guidelines for acute care. Acute Care Guidelines state that $1118.00 is a valid reimbursement for a full day of inpatient care, or approximately 24 hours. By definition, outpatient or ambulatory surgical services are those that require less than 90 minutes anesthesia time and less that [sic] four hours of recovery. This means the patient receives care from the facility for ¼th of the time of being in an inpatient setting for a full day, and the facility is paid at the **equivalent of** a one day inpatient stay. **The Acute Care Fee Guidelines were used as a consideration in determining reimbursement-However, this does not mean that inpatient guidelines were applied to this service…**. While the S.O.A.H. decisions are not binding on the Commission, the ALJ's do point out that cost effectiveness must be proven, and that 'other carriers willingness to pay at higher rates' does not prove the provider's fees are effective cost control."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 07/03/01.

2. The total amount in dispute is $4904.68.

3. The carrier's denial is based on fair and reasonable reimbursement.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…"

Section 413.011 (b) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

Rule 133.307 (g) (3) (D) places certain requirements on the provider when supplying documentation with the request for dispute resolution. The provider is to discuss, demonstrate, and justify that the payment amount being sought is fair and reasonable. Commission Rule 133.304 (i)(1-4) places certain requirements on the carrier when reducing the billed amount to fair and reasonable. Regardless of the carrier's methodology or lack thereof, or a timely or

untimely response, the burden remains on the provider to show that the amount of reimbursement requested is fair and reasonable.

The provider has submitted EOBs from other carriers as examples of "fair and reasonable" reimbursement for same or similar services. These EOBs were paid at varying percentages of the billed amount. The willingness of some carriers to provide reimbursement at or near the billed amount does not necessarily document that the billed amount is fair and reasonable and does not show how effective medical cost control is achieved, a criteria identified in Sec. 413.011 (b) of the Texas Labor Code. Therefore, based on the evidence available for review, the Requestor has not established entitlement to additional reimbursement. No further reimbursement is recommended.

The above Findings and Decision are hereby issued this 28th day of August 2002.

Carolyn Ollar, RN, BA
Medical Dispute Resolution Officer
Medical Review Division
CO/co

This document is signed under the authority delegated to me by Richard Reynolds, Executive Director, pursuant to the Texas Workers' Compensation Act, Texas Labor Code Sections 402.041 - 402.042 and re-delegated by Virginia May, Deputy Executive Director.